RULES OF ENGAGEMENT

2022 Agent and Agency Sales Handbook, Effective 7/1/2021

Together, all the way.®

Cigna®

954290 06/21

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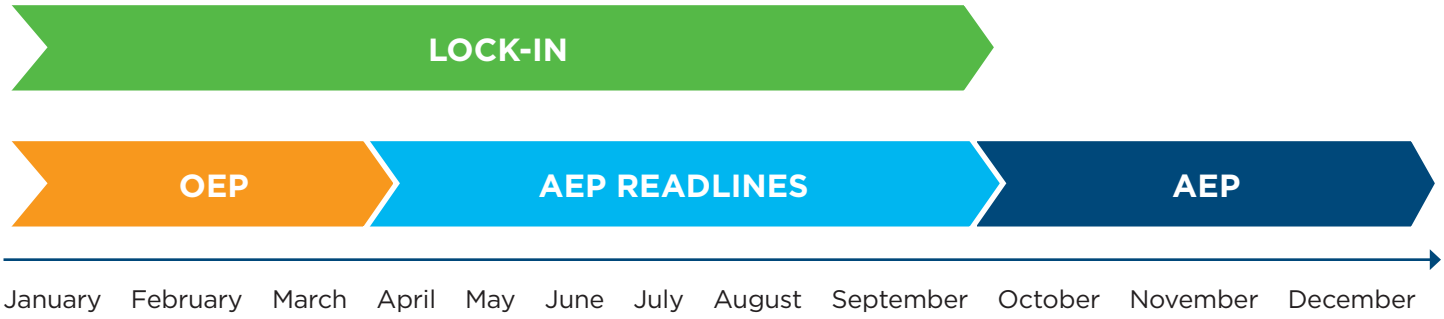
To open links within this document that are part of **Producers' University**, Agent/Agency must be logged into the system prior to opening.

KEY ACRONYMS AND TERMINOLOGY

AEP	Annual Enrollment Period
Agent	Exclusive or Non-exclusive Broker
AOC	Assignment of Commissions
AOR	Agent of Record
CARL	Cigna Agent Resource Line
CMS	Centers for Medicare and Medicaid Services
CSV	Customer Service Violation
CTM	Medicare Complaints Tracking Module
DOB	Date of Birth
Downlines	Agencies not directly contracted with Cigna
DSA	Delegated Services Agreement
EFT	Electronic Funds Transfer
FDR	First Tier, Downstream and Related Entities
FMO	Field Marketing Organization
FTP	File Transfer Protocol
GA	General Agency
HPMS	Health Plan Management System
MA/MAPD	Medicare Advantage and Prescription Drug
MAO	Medicare Advantage Organization
MCMG	Medicare Communications and Marketing Guidelines
MGA	Managing General Agency
MIPPA	Medicare Improvements for Patients and Providers Act
NPN	National Producer Number
PDP	Prescription Drug Plan
Personal Business Entity	Business entity that commissions are assigned to but does not qualify as an Agency
PHI	Personal Health Information
RFI	Request for Information
ROE	Rules of Engagement
SDAP	Sales Development Action Plan
SGA	Supervising General Agency
SOA	Scope of Appointment
SSA	Social Security Administration
SSN	Social Security Number
TIN	Tax Identification Number
Topline(s)	Directly contracted Agencies
Upline	Upstream Agency

SECTION II

CALENDAR YEAR AT A GLANCE



January

- OEP begins
- AEP new application commissions distributed
- Full-year advance annual renewal payments issued

March

- Agency **Producers' University** attestation and updated business license/appointment final deadline: 3/31; ***failure to complete will result in forfeiture of commissions and/or Agency administrative fee renewals**
- OEP ends 3/31

April

- **AHIP** reimbursement distributed for Agents who meet **qualifications**

July

- Annual certification release
- Deadline for call centers completing the telesales intake process to submit all paperwork to finalize onboarding in time for upcoming AEP: 7/1

September

- Blackout period begins for hierarchy changes: 9/1 through 12/31; ***All requests for self-release in process prior to 7-1 will be honored if the hierarchy change paperwork is submitted on or before 10-15. All others will need to be resubmitted for processing after 1-1-22.**
- AHIP reimbursement eligibility deadline: 9/1

October

- AEP Marketing period begins: 10/1
- AEP Sales period begins: 10/15

November

- Last day for current plan year effective sales: 11/30

December

- AEP ends: 12/7
- Agent certifications and up-to-date licenses and appointments deadline: 12/31; ***failure to complete will result in forfeiture of commissions and/or Agency administrative fee renewals**
- Agency **Producers' University** attestations and updated business license/appointments deadline for timely renewals: 12/31

SECTION III

RECRUITMENT AND ONBOARDING

Recruitment Ethics

- As an Agency grows through recruitment campaigns, it is common to come across existing Cigna Medicare Agents and Agencies. As a rule, Agencies cannot contract with any current directly contracted or employed Cigna Medicare Agent without written consent from Cigna Medicare.
- As a general guideline, Cigna requests the Agency respectfully walk away from any current Cigna Medicare Agent or Agency writing under an existing hierarchy. To assist Agencies in minimizing outreach, Cigna Medicare's local market can scrub its recruitment list to remove those actively contracted.

Qualifications

Action	Agent	Agency
Complete Cigna Medicare Credentialing.	✔	✔
Complete Agency attestations administered by Cigna Medicare upon contracting and annually thereafter on **Producers' University**.		✔
Complete Cigna Medicare Training and Certification (prior to selling and annually thereafter) on **Producers' University**.	✔	
Complete any instructor-led virtual or in-person training that may be required by Cigna Medicare.	✔	✔
Hold appropriate active health insurance license in good standing within the state(s) Agency or Agent intend to market and submit Cigna Medicare applications.	✔	✔
Be appointed by Cigna Medicare in the states Agent/Agency sells and submits applications, either prior to selling or after the first sale as applicable, per state regulations.	✔	✔
Have an executed agreement with an FMO, an SGA, an MGA, a GA or Cigna Medicare.	✔	✔
Comply with all legal, compliance and regulatory guidance in accordance with applicable state/federal laws and Cigna Medicare policies.	✔	✔
Receive continuing education relative to the current MA/MAPD products and comply with any changes that occur relative to this program.	✔	✔
Attend all meetings required by Cigna Medicare to stay informed of compliance, regulatory, procedural and network changes.	✔	✔
Participate in integrity oversight evaluations and the Cigna Medicare SDAP as required by CMS and Cigna Medicare.	✔	✔
Have valid email address on file for receiving communications concerning immediate regulatory or network changes.	✔	✔
Maintain a proficiency in and knowledge of Cigna's MA/MAPD products as well as all necessary compliance requirements.	✔	✔
Comply with Cigna Medicare sales performance and disciplinary standards as set forth in this *Rules of Engagement Handbook* and the *Cigna Medicare Policy Handbook*.	✔	✔
Have an executed HIPAA Agreement or Business Associate Agreement with Topline or directly with Cigna Medicare.	✔	✔

Contracting

Contracting Process

To sell Cigna Medicare products, all Agents/Agencies must be properly credentialed and contracted. Cigna Medicare has chosen **Producer Express** (Sircon) as the data source for their eContracting system. To start the contracting process, **external Topline Agencies are responsible for initiating onboarding and maintenance requests for all Downline Agencies and Agents through the eContracting system**. Once the contracting information is completed by appropriate Downline and submitted to Cigna Medicare, a background check is initiated and Cigna Medicare will submit pre-appointments as applicable by state per the contract request. Following successful completion of the background check and appointment processing, as applicable, Agents will receive access to **Producers' University** to register for and complete Certification. Upon successful completion of this contracting process, background check and certification, Agents/Agencies in good standing will be activated as Ready to Sell (RTS) in states where they maintain proper licensure and appointments per state regulations. In order to service customers and maintain renewal commissions, Agents/Agencies must remain in good standing and continue to meet all validations (actively contracted, certified, licensed, appointed). For further specific Telesales Agency-related onboarding, see the **Call Center Intake Section** of this document.

Additional contracting resources:

- **Recruiter Workspace 101**
- **eContracting Agency**
- **eContracting Agent**

Note: Selling principals must also complete a separate Downline Agent contract packet to contract as an individual selling Agent.

Second Note: Direct Deposit EFT forms must be downloaded from contracting portal and submitted per the instructions on the document.

Bulk Onboarding

Agencies must meet minimum onboarding requirements, meet or exceed Cigna Medicare background check standard requirements, and be approved by Cigna Medicare in order to utilize bulk onboarding for Downline Agents. Should Agency be approved for bulk onboarding, Cigna Medicare may perform ongoing criminal background checks on any or all appointed Agents.

Licensing and Appointments

All Agents/Agencies must be licensed and appointed in all states they market and sell Cigna Medicare products. Agents/Agencies are responsible for obtaining and keeping the appropriate licensure (Note: Rules vary by state) and must remain licensed and appointed to service customers in order to continue receiving renewal commissions. Cigna Medicare will only appoint in advance for pre-appointment states where Cigna actively sells Medicare business, as required by state regulations. Where state law permits, the appointment(s) will be requested after the first sale is received by Cigna Medicare. A valid license must be held regardless of appointment process used. For additional questions, contact applicable Topline or Local Market Manager for further details.

When an Agent/Agency intends to sell Cigna Medicare products in additional pre-appointment state(s), they must inform their recruiter, who will initiate the request. Agent/Agency is not approved to begin selling in additional pre-appointment state(s) until confirmation is received from Cigna Medicare of the specific state appointment(s).

If an Agent or Agency has any additional questions or needs assistance with any part of the onboarding process, please contact **CARL**.

Errors and Omissions

Cigna requires all Agencies to carry an Errors and Omissions (E&O) policy consistent with industry standards but at least $1,000,000 per occurrence and $3,000,000 aggregate limit with a reasonable deductible. The Agency is required to notify Cigna of any reduction, modification, cancellation or termination of the E&O insurance.

The Agency and their Topline (if applicable) are required to ensure all individuals employed by or contracted by the Agency (including Subordinate Agents) shall maintain E&O Insurance. E&O policies should be consistent with industry standards but at least $1,000,000 per occurrence and $1,000,000 aggregate limit with a reasonable deductible, or the applicable state required coverage amounts. The Agency and their Topline (if applicable) are required to provide evidence of such coverage upon request.

Failure to maintain adequate E&O Insurance in accordance with the Sales Agreement and Rules

of Engagement may be considered a breach of the Agreement and may lead to disciplinary actions up to and including termination.

Hierarchy Change to a New Topline

When an Agency/Agent changes hierarchy, residual Administrative Fees are retained by the hierarchy structure and are subject to the contract terms in place at the time of the original sale. Hierarchy changes are accepted by Cigna Medicare January 1 through August 31.

Hierarchy Blackout Period

Hierarchy changes are not permitted from September 1 to December 31.

Requirements

- Must be in good standing with Cigna Medicare.
- Cannot be under investigation internally or externally and must have acceptable compliance metrics.
- Must not have a third-party paper prohibiting a move in hierarchy.
- Must have an active writing number with Cigna Medicare.
- **Must transfer to the same or lower contract level with new Topline Agency.**
- Must be successfully released per the following.

How to Obtain a Release

1. Obtain a release letter signed by the current Topline Agency. (If Topline does not have their own release form, Agents may use Cigna's generic "**Release and Request for Self Release from Topline Form**" located on **Producers' University**.)
2. If the Agent has been continuously active under the same Topline Agency for at least the previous ninety (90) calendar days but has not produced any business during that time, no release is required to change hierarchies.
3. If the Topline Agency is unwilling to grant a release, and the Agent/Agency has produced business in the previous ninety (90) calendar days, the Agent/Agency can submit a signed and dated "**Release and Request for Self Release from Topline Form**" located on **Producers' University** to **CARL**. This will serve as the Agent's/Agency's notice of intent to change to a new sales hierarchy and will start a ninety (90) calendar-day waiting period to be eligible to switch hierarchies without a release. The ninety (90) calendar-day time frame for a release officially begins on the day the **CARL** email box receives the release form.

For all move requests, changes are required to be processed within 60 days of the date the Agent/Agency is eligible to move (date of release letter or 90-day waiting period end date), or a new request, qualification check and waiting period are required.

Limitations

After the initial acknowledgment of the change request, no additional notices or reminders will be sent from Cigna Medicare regarding the eligibility date. At the end of the ninety (90) calendar-day waiting period, the Agent/Agency will be free to onboard with the Agency of their choosing.

Agents may continue to sell during the ninety (90) calendar days, but the business sold in that ninety (90) calendar-day time frame remains under the hierarchy in place at the time the business is written.

The accepting Topline Agency is responsible for initiating an onboarding e-vite for the Agent/Agency in **Producer Express** (Sircon). Agents/Agencies in the Topline hierarchy are permitted to change sales hierarchies no more than once per calendar year under the ninety (90) calendar-day notice scenario (option 3 above).

When an Agency is released, the contracted Downline Agents/Agencies are considered to be included in that release, unless other arrangements are requested by the Topline Agency and approved by Cigna Medicare. The accepting Topline Agency is responsible for initiating onboarding e-vites for any/all Downline Agents/Agencies in **Producer Express** (Sircon).

An Agent/Agency must transfer to the same or lower contract level with the new Topline Agency. The Agent/Agency may only upgrade to a higher contract level after twelve (12) months from the change date and if Downline Agent and production requirements are met and Cigna Medicare approval is granted.

Hierarchy Change Within Same Topline

The Topline Agency has discretion to move and change the level of Agents and solicitors within their hierarchy structure at a reasonable frequency. The Topline Agency does not need the consent of the Agent or Agency

to complete a move or downgrade within its own hierarchy. The Topline does, however, need to notify the Agent/Agency of the move or downgrade. The Topline Agency will initiate an agreement maintenance e-vite for any move or downgrade requests, which will be completed by the Agent/Agency and submitted to Cigna Medicare. Residual override commissions are retained by the hierarchy structure and are subject to the contract terms in place at the time of the original sale. The Topline Agency is responsible for initiating agreement maintenance e-vites for any Downline Agents/Agencies in **Producer Express** (Sircon).

Agent/Agency Training and Certification

Overview

Cigna Medicare approaches training as a tool to help our Agents and Agencies become successful and requires Agents to maintain a proficiency in and knowledge of Cigna's MA/MAPD plans as well as all necessary compliance requirements. To this end, we offer a variety of performance-focused training and ongoing learning opportunities for all our new and existing Agents and Agencies. Training and certification can be accessed through the Cigna Medicare **Producers' University** at **www.CignaMedicareProducers.com**. Access to **Producers' University** is provided to Agents/Agencies once the contract has been submitted to Cigna Medicare and will remain active as long as the Agent/Agency maintains an active agreement with Cigna Medicare. While many courses are self-paced e-learning, which allows Agents to learn at their own pace, a few course are instructor led (face-to-face) or virtual instructor led (webinars) while others are offered as blended learning, incorporating both e-learning and instructor-led content.

Certification

Certification is required upon contracting as an Agent and annually thereafter by the date specified by Cigna Medicare.

Requirements to Obtain/Maintain Active Status

- Complete certification prior to selling any Cigna Medicare products.
- Complete standard Medicare training, referred to as "universal" training, and Cigna Medicare-specific courses.
- Pass each course with a minimum score of 85%.
- Pass each course in no more than three attempts.
  - Agents should contact **CARL** in the event a course is failed three times and locked.

Acceptable External "Universal" Medicare and Fraud, Waste and Abuse Training and Cigna Medicare Certification Cost Reimbursement

Cigna Medicare will reimburse certification costs for 2022 Medicare Advantage Agent certification where eligibility requirements are met. **To be eligible for reimbursement, Agents must complete 2022 certification by September 1, 2022, and sell at least five (5) fourth (4th) quarter 2021 or January 1, 2022, effective date applications on or before December 31, 2021, that are in good order and active.** After meeting these requirements, **qualified** Agents will be eligible for reimbursement as outlined below:

- AHIP ($125 reimbursement) **www.AHIPMedicareTraining.com**
- Pinpoint Global ($99.95 reimbursement) **https://medicareonlinecertification.com**

Both AHIP and Pinpoint Global certifications can be accessed directly from the **Producers' University**.

For reasons of emphasis, clarity or CMS directives, Cigna Medicare's certification courses may repeat certain topics that Agents may have covered in the external certification administered by AHIP, Pinpoint or Gorman.

Note: External Telesales Agents are not eligible for reimbursement under this policy.

Training Steps

- Go to **Producers' University**.
- Log in with the NPN and password.
- Click "My Learning" to see tracks.
- Select any course to start. Agents have three attempts to pass each course.
- Launch and complete AHIP or Pinpoint Medicare Training, or upload a valid certificate from AHIP or Pinpoint.

Cigna Medicare's training and testing programs are designed and implemented in a way that maintains the integrity of the training and testing and ensures that each individual is taking the test independently. Agents may not allow someone else to complete training on their behalf or share their logins to the Cigna Medicare **Producers' University** with anyone else. Doing so will violate the integrity of the training process and CMS Agent and Testing Guidelines. Cigna Medicare maintains evidence of the training tools, training exams and documentation demonstrating evidence of completion and can provide this information to CMS upon request.

Note: Agents and Agencies must have an active agreement with Cigna Medicare to access Cigna Medicare Training.

Annual Attestation

Agents and Agencies are required to agree to and abide by the *Cigna Medicare Policies Handbook ROE, and Social Media Policy* through electronic attestation prior to marketing or selling any of our products and annually thereafter by the deadlines communicated by Cigna Medicare. **Note:** Selling principals must complete both their individual Agent attestation as well as their Agency attestation separately. Attestations can be changed at the discretion of Cigna Medicare. Failure to complete required attestations by the final deadline communicated by Cigna Medicare will result in forfeiture of Agent-level commissions and/or Agency administrative fee renewals. See **Calendar Year at a Glance** for deadlines.

Certification Curriculum*

Course Name	Key Focus
Selling with Integrity**	› Our selling process › How to sell consultatively and compliantly in one-on-one setting and telephonically › Our value proposition
Products and Benefits Overview	› Line of products and features › Model of Care › Eligibility › Snapshot of all plans and the key benefits
Our Compliance Program	› Key requirements of our Compliance Program › HIPAA and Compliance culture › Agent's role in our Compliance Program › Reporting violations
New Agent Training***	Doing business with Cigna: tools, processes, key requirements and our value proposition
Attestations	Review and attestation of Rules of Engagement, Policies Handbook, and Social Media Communications and Marketing Policy
Cigna Rx (PDP)	Our stand-alone Part D product

* The curriculum and content may change slightly from year to year.

** Selling with Integrity is offered in three different versions: Field, Telesales, and Combined Field and Telesales. Agents will be assigned one based on their contract or their Upline's contract with us. If an Agent switches channels (e.g., Field to Telesales), the Agent will be required to complete the appropriate Selling with Integrity course in order to fulfill training requirements for the new channel.

*** New Agent Training is recommended for all newly contracted Field Agents and may be online, instructor led (face-to-face) or virtual instructor led.

Remediation Training

This training is focused on helping Agents improve compliance performance and satisfy violation requirements.

- Remediation courses are assigned as needed and may require Agents to retake a previously completed course
- Agents are required to complete in a timely manner to continue to be in good standing with Cigna Medicare
- A coaching session with a Cigna Medicare employee may be a required component of the remediation training

Invitation Only

Certain training courses and events are invitation only. When applicable, Agents will be invited to register for the training and attend online or in person. An example of this is our Sales Event Training for Agents who have been elected to conduct sales events on behalf of Cigna Medicare.

Ready to Sell

Welcome Email and Call

Upon successful completion of the credentialing process and contract processing, a Welcome email will be generated to the Agent/Agency that includes the following:

- Cigna Medicare Writing Number/Agent ID
- Pre-appointment States Agent is Appointed in
- Direct Upline/Topline Name
- Link to **Rules of Engagement**
- **Quick Guide**
  - List of important websites and contact information needed to succeed at Cigna
- **Site Credentials**
  - Provides information to help remind Agents of credentials to log in to each Cigna-regulated website

Agents will also receive a welcome call from Cigna's Agent Resource Line to answer any questions and assist with initial sales kit orders.

SECTION IV

INSPIRING TOPLINES

What Is Expected

Cigna recognizes the desire for growth for our Downline Agency partners. As we work together to build a growth strategy, we find it important to share base standards all Toplines have to meet to be considered for a Topline contract review as operational foundations are built.

- Topline must review the overall Topline Report Card with Downline Agencies and individual Agents.
- Topline, Downline Agencies and individual Agents must actively participate in Cigna-oversight activities as updated or revised from time to time at Cigna's sole discretion, which may include, but are not limited to the following:
  - Periodic review of contractual obligations to ensure requirements are met.
  - Participation in Cigna's Ride Along Program.
    - Agents are evaluated to ensure their presentation meets Cigna and CMS requirements and must receive a passing score.
  - Participation in Cigna's Secret Shopper Program.
    - Each Agent must receive a passing score.
  - Review of applications to ensure they are completed and submitted in a timely manner per Cigna and CMS standards.
  - Review SOAs to ensure they are obtained and completed per Cigna and CMS standards.
  - As applicable, ensure sales events are approved by Cigna prior to event.
  - Regularly review rapid disenrollment, complaint and void rates to ensure they do not exceed acceptable thresholds.
  - Periodic review of other Cigna policies and procedures to ensure compliance.
  - Topline complies with, and requires Downline Agencies and Agents to agree to comply with, all requests for compliance documentation to support a Cigna audit request, reviewing potential violations of CMS or Cigna requirements, and/or a CMS audit request. Additionally, Topline provides and requires Downline Agencies and Agents to provide documentation demonstrating compliance with all CMS regulations and/or Cigna requirements.
- Toplines' are required to provide data and analysis to enable Cigna to meet all regulatory and oversight requirements, which may include:
  - Reports.
  - Downline Agreements.
  - Amendments to Downline Agreements.

SECTION V

FDR OVERSIGHT GUIDE

FIRST TIER, DOWNSTREAM, OR RELATED ENTITY DEFINED

CIGNA partners with First Tier, Downstream and Related Entities (FDRs) to deliver administrative and health care services that support our Medicare and Medicaid Plans and CMS agreements. CIGNA maintains the ultimate responsibility for fulfilling the terms and conditions of its contract with CMS, and for meeting the Medicare program requirements. CMS holds CIGNA accountable for ensuring its FDRs comply with Medicare program requirements. **Therefore, CIGNA holds all FDRs accountable for complying with Medicare program requirements.**

An FDR is any Agent/Agency contracted by CIGNA to complete any administrative and/or health care related functions pertaining to CIGNA's Medicare and Medicaid contracts. CMS defines First Tier, Downstream and Related Entities as follows:

First Tier Entity is any Agency that enters into a written arrangement, acceptable to CMS, with a Medicare Advantage Organization (MAO) or Part D plan sponsor or applicant to provide administrative services or health care services to a Medicare-eligible individual under the MA program or Part D program.

Downstream Entity is any Agent/Agency that enters into a written arrangement, acceptable to CMS, with persons or entities involved with the MA or Part D benefit, below the level of the arrangement between an MAO (or applicant) or a Part D plan sponsor (or applicant) and a First Tier Entity. These written arrangements continue down to the level of the ultimate provider of both health and administrative services.

Related Entity is any Agent/Agency that is related to an MAO or Part D plan sponsor by common ownership or control and meets one of the following parameters:

- Performs some of the MAO or Part D plan sponsor's management functions under contract or delegation
- Furnishes services to Medicare enrollees under an oral or written agreement

See 42 C.F.R. §§ 422.500 and 423.501 for more information.

Cigna FDRs are considered delegated entities. They fall into this category by performing Sales and Marketing on behalf of Cigna. Cigna is the brand name used for products and services provided by one or more of the Cigna group of subsidiary companies.

FDR COMPLIANCE PROGRAM REQUIREMENTS

This guide summarizes the requirements of Cigna's FDR Compliance program that each FDR and their downstream entities must fulfill. FDR adherence to Cigna's compliance program also ensures compliance with applicable federal and state laws and regulations.

In addition to this guide, information can be found within the following documents or sets of documents:

- FDR Contract
- Cigna Policies and Procedures
- Compliance Program Guidelines in Chapter 21 of the *Medicare Managed Care Manual*
- Chapter 9 of the *Prescription Drug Benefit Manual*

If Agency/Agent fails to meet Cigna's FDR compliance program requirements, it may lead to:

- Development of a corrective action plan
- Retraining
- Termination of FDR contract and relationship with Cigna

CMS Guidance	Best Practices to Ensure Compliance
Element I: Written Policies, Procedures and Standards of Conduct **Chapter 21 § 50.1** Sponsors must have written policies, procedures and standards of conduct that: 1. Articulate the sponsor's commitment to comply with all applicable Federal and State standards; 2. Describe compliance expectations as embodied in the Standards of Conduct; 3. Implement the operation of the compliance program; 4. Provide guidance to employees and others on dealing with suspected, detected or reported compliance issues; 5. Identify how to communicate compliance issues to appropriate compliance personnel; 6. Describe how suspected, detected or reported compliance issues are investigated and resolved by the sponsor; and 7. Include a policy of non-intimidation and non-retaliation for good faith participation in the compliance program, including, but not limited to, reporting potential issues, investigating issues, conducting self-evaluations, audits and remedial actions, and reporting to appropriate officials.	› FDRs must have written Policies & Procedures and a Compliance Policy (Standards of Conduct, Code of Conduct or Code of Ethics), approved by Cigna, that are comparable to or exceed elements found in Cigna's Code of Ethics found at **Code of Ethics and Principles of Conduct | Cigna**. › Compliance policies should be distributed to employees within 90 days of hire, upon revision, and annually thereafter. You may choose your distribution method but you must maintain documentation. › Cigna's FDR Oversight team will review your compliance procedures and code of conduct annually. › Your code of conduct and policies and procedures must: – Articulate your commitment to comply with all applicable federal and state requirements – Describe compliance expectations as embodied in the Standards of Conduct – Describe ethical behaviors and compliance program operations – Explain how suspected, detected or reported compliance issues are investigated and remediated; and – Describe your non-retaliation protections for individuals that make good faith reports of suspected FWA
Element II: Compliance Officer, Compliance Committee and High Level Oversight **Chapter 21 § 50.2** The sponsor must designate a compliance officer and a compliance committee who report directly and are accountable to the sponsor's chief executive or other senior management.	› A roster of the FDR's Compliance Committee, including the Compliance Officer, and contact information must be provided to Cigna › FDR Oversight should be notified of any future changes/updates to the Compliance Officer

CMS Guidance	Best Practices to Ensure Compliance
Element III: Effective Training and Education **Chapter 21 § 50.3** The sponsor must establish, implement and provide effective training and education for its employees, including the CEO, senior administrators or managers, and for the governing body customers, and FDRs.	**Training requirements:** › Fraud, Waste, and Abuse and General compliance training must be completed within 90 days of hire (or contracting), when materials are updated, and annually thereafter › Certification is required within 90 days of initial hire or the effective date of contracting, and annually thereafter. › A record of employees requiring the training, completing the training, and the materials utilized for training must be retained for ten (10) years and be made available upon request by Cigna. › Annually, Cigna performs Compliance Program Effectiveness Monitoring and we will request evidence to support your training. Supporting Evidence must be in the form of a certificate of training or a sign in sheet of employees who completed the training on a particular day. If you use training logs or reports as evidence of completion, they must include: – Employee names or individual identification numbers – Dates of completion – Passing scores (if captured)
Element IV: Effective Lines of Communication **Chapter 21 § 50.4** The sponsor must establish and implement effective lines of communication, ensuring confidentiality between the compliance officer, customers of the compliance committee, the sponsor's employees, managers and governing body, and the sponsor's FDRs. Such lines of communication must be accessible to all and allow compliance issues to be reported including a method for anonymous and confidential good faith reporting of potential compliance issues as they are identified.	› FDR employees must be aware of how to report suspected or detected non-compliance or potential Fraud, Waste, or Abuse, and that it is their obligation to report without fear of retaliation or intimidation against anyone who reports in good faith. › FDR Employees and other Downstream Entities may report concerns directly to Cigna, using the Cigna **Ethics Helpline (1.800.472.8348 Confidential and Available 24/7)** or **Fraud Hotline (1.800.667.7145 Confidential and Available 24/7)**. In addition, an FDR may maintain confidential and anonymous mechanisms for employees, Agents to report internally.

CMS Guidance	Best Practices to Ensure Compliance
Element V: Well-Publicized Disciplinary Standards **Chapter 21 § 50.5** Sponsors must have well-publicized disciplinary standards through the implementation of procedures which encourage good faith participation in the compliance program by all affected individuals. These standards must include policies that: 1. Articulate expectations for reporting compliance issues and assist in their resolution; 2. Identify non-compliance or unethical behavior; and 3. Provide for timely, consistent, non-complianceand effective enforcement of the standards when or unethical behavior is determined.	› Policies and procedures must be in place for all employees or entities and their employees, to report any relationships external to the organization or Cigna that may present a potential conflict, at time of hire, within 90 days and annually thereafter. › Cigna should be notified immediately if any conflict exists. › FDRs must have written Policies & Procedures and a Compliance Policy (Standards of Conduct, Code of Conduct or Code of Ethics), approved by Cigna, that are comparable to or exceed elements found in Cigna's Code of Ethics found at **Code of Ethics and Principles of Conduct | Cigna**.
Element VI: Effective System for Routine Monitoring, Auditing and Identification of Compliance Risks **Chapter 21 § 50.6** Sponsors must establish and implement an effective system for routine monitoring and identification of compliance risks. The system should include internal monitoring and audits and, as appropriate, external audits, to evaluate the sponsor's, including FDRs', compliance with CMS requirements and the overall effectiveness of the compliance program.	› FDR should review Office of Inspector General (OIG), General Services Administration (GSA), and State exclusions, OFAC list prior to hire and monthly thereafter to ensure no employee, temporary employee, volunteer, consultant, governing body customer responsible for administering or delivering Medicare and/or Medicaid benefits are excluded from the Federal/ State health care programs. › FDR must document and retain evidence of the OIG and GSA/SAM exclusion checks / screenings Documentation must include: › The person/entity full name › Date when screening was conducted › Results of the screening conducted › Actions taken › FDR must take action if an issue is discovered; therefore, if any employees* (permanent or temporary) or downstream entities are on one of the exclusion lists, they must immediately be removed from work directly or indirectly related to Cigna's Medicare plans, and Cigna must be notified. › Conduct routine internal oversight of the services performed to ensure that activities within organization and downstream entities are in compliance with applicable laws, rules, and regulations including CMS regulatory/ sub-regulatory guidance. * Applies to all employees not just selling Agents.

* Applies to all employees not just selling Agents.

CMS Guidance	Best Practices to Ensure Compliance
Element VII: Procedures and System for Prompt Response to Compliance Issues **Chapter 21 § 50.7** Sponsors must establish and implement procedures and a system for promptly responding to compliance issues as they are raised, investigating potential compliance problems as identified in the course of self-evaluations and audits, correcting such problems promptly and thoroughly to reduce the potential for recurrence, and ensuring ongoing compliance with CMS requirements.	› FDRs must conduct appropriate corrective actions (for example repayment of overpayments, disciplinary actions against responsible employees) in response to the potential violation. › If FDRs discover evidence of misconduct related to payment or delivery of items or services under the contract, the FDR must conduct a timely, reasonable inquiry into that conduct.

Offshore Operations

To ensure Cigna complies with applicable federal and state laws, rules, and regulations, FDRs are prohibited from using any individual or entity (offshore entity) to perform services for Cigna's Medicare plans if the individual or entity is physically located outside the United States or one of its territories (that is, American Samoa, Guam, Northern Marianas, Puerto Rico and Virgin Islands). The only exception to this is if an authorized Cigna representative agrees in advance and in writing to the use of such offshore entity. **Notify Cigna immediately if planning to use an offshore entity. Additional requirements may apply.**

Fraud, Waste and Abuse (FWA)

Cigna FDRs play an important role in protecting the integrity of the Medicare oversight program. To combat FWA, it is imperative to know what FWA is and how to protect against engaging in abusive practices and/or civil or criminal law violations.

FWA Defined

Fraud is intentionally misusing information to persuade another person or entity to part with something of value or to surrender a legal right. It could also be an act of planned deception or misrepresentation.

Waste is using, consuming, spending or expending resources thoughtlessly or carelessly.

Abuse is providing information or documentation for a health care claim in a manner that improperly uses program resources for personal gain or benefit but without sufficient evidence to prove criminal intent.

FWA Laws

Federal laws governing Medicare FWA include:

- **Federal False Claims Act**
- **Anti-Kickback Statute**
- **Physician self-referral, or the "Stark law"**
- Social Security Act
- United States criminal code

FWA and Compliance Concerns

There are a number of ways to confidentially report suspected or detected non-compliance or potential FWA regarding the sale of Cigna products:

- The FDR Oversight Team at FDROversight@Cigna.com
- Your Cigna broker account manager, who will then alert the FDR Oversight Team
- Our company **FWA Hotline** at **1-800-667-7145** or our **Ethics Line** at **1-800-472-8348**

Egregious policy violations that impact the beneficiary should be reported immediately (within 24 hours).

FDR Monitoring and Auditing

In accordance with CMS requirements, Cigna routinely monitors and periodically audits FDRs. This helps ensure compliant administration of CMS contracts and compliance with applicable laws and regulations. Each FDR must take part in these monitoring and auditing activities and be prepared to provide results upon request.

Downstream Entity Monitoring

FDRs are responsible for monitoring any downstream entities with which they contract, ensuring subcontractors abide by all laws and regulations that apply to a First Tier Entity. Examples of downstream monitoring include:

- Ensuring that contractual agreements contain all CMS-required provisions
- Ensuring adherence to Medicare compliance program requirements described in this guide
- Ensuring compliance with any applicable Medicare operational requirements

FDRs must:

- Conduct auditing and monitoring to test and ensure employees and Downstream Entities are compliant
- Retain evidence of auditing and monitoring results, as this may be requested at any time
- Ensure that root cause analysis is conducted for any deficiencies
- Implement corrective actions, including disciplinary actions, such as contract termination, to prevent recurrence of non-compliance

These requirements are found in:

- 42 CFR § 422.503(b)(4)(vi)(F) for MA
- 42 CFR § 423.504(b)(4)(vi)(F) for Part D
- Medicare Managed Care Manual, Chapter 21 § 50.6.6

FDRs may be subject to other federal and state laws, rules, and regulations that must also be fulfilled but are not covered in this guide. Cigna expects compliance with all applicable federal and state laws, rules, and regulations. Please contact your Cigna account manager or email **FDROversight@Cigna.com** with any questions about compliance obligations.

FDR Performance Tracking

Cigna has developed metrics and benchmarks for the monitoring of FDRs. This data is subject to change pursuant to CMS and Cigna rules and regulations. FDRs will receive quarterly report cards tracking metrics and benchmarks (in parentheses) including, but not limited to, the following:

Complaints – CTMs and CSVs

Accreted Rates **(≥ 90%)**

Rapid Disenrollment Rates **(≤ 15%)**

Ride Alongs **(≥ 80%)**

Secret Shopper Results **(≥ 95%)**

Sales Events **(≤ 5%)**

Timeliness of Applications **(≥ 97%)**

Voids **(≤ 10%)**

FDRs are required to review report cards and discuss any areas of non-compliance with their downstream entities. Upon request, FDRs must provide evidence they have met with the compliance contact of the downstream entities, have reviewed the data, have taken action as appropriate and have remediated any non-compliance. From time to time, specific action may be required by Cigna and/or CMS. This action will be tracked pursuant to Cigna processes and documented accordingly.

SECTION VI

CALL CENTER INTAKE

Telesales Requirements

Establishing a Telesales Agency with Cigna Medicare

At Cigna, we believe in providing quality care and responsive service to our customers when and where they need it. We are focused on putting our customers at the center of all we do and welcome Agencies that share this focus. These guidelines provide additional details on how to establish a compliant and customer-focused telesales Agency on behalf of Cigna Medicare.

All state/federal and Cigna Medicare requirements must be followed by any organization that will perform telephonic enrollment functions (telesales). The following minimum requirements outline what is necessary to implement and maintain telesales functions on behalf of Cigna Medicare.

Telesales Agency Criteria

- Telesales Agencies are required to adhere to the telesales setup criteria, the Telesales Addendum in the DSA, and telesales policies and procedures.
- If the organization does not adhere to the telesales requirements, and if appropriate remediation action is not taken within 72 hours of written notice, the organization may be subject to immediate termination.
- The telesales function will be evaluated on an annual basis to ensure compliance with CMS guidelines, Cigna Medicare policies and contract adherence with regard to telesales production.
- The Agency must create and maintain all applicable policies and procedures to support the telesales functions, which include both technical and administrative safeguards.
- Caller ID spoofing is prohibited. "Caller ID spoofing" or "spoofing" is a practice where a caller (e.g., an Agent) makes a telephone call to a potential customer using a technology that helps mask the caller's identity by showing the recipient a caller ID telephone number that is different from the caller's actual telephone number. This often occurs when robocall technology is utilized. Spoofing is illegal under the Truth in Caller ID Act, which makes illegal the transmission of misleading or inaccurate caller ID information with the intent to defraud, cause harm or wrongly obtain anything of value. Anyone who engages in illegal spoofing can face penalties of up to $10,000 for each violation. Cigna requires that all Agents comply with all applicable federal and state laws. Cigna does not approve of the use of caller ID spoofing technology and will terminate its relationship with any Agent who is found to be using the technology to mislead potential customers. We encourage all Agents to review the Federal Communications Commission website to learn more about the Truth in Caller ID Act and customer issues associated with robocalling: **https://www.fcc.gov/customers/guides/stop-unwantedrobocalls-and-texts**.
- The telesales Agency should have a point of contact for daily management as well as escalation issues.

Any violation of Cigna Medicare or state/federal requirements may result in disciplinary action up to and including termination of the Cigna Medicare contract.

Licensure and Training

- All Agents and Agencies are required to comply with the rules outlined in the **Licensing and Appointment** section of this guide.
- Agents are required to follow the **Training Steps** section of this guide. Once all training is complete per the **Certification Curriculum** specific to telesales Agents, the Agent will be made "Active." Agents will only be ready to sell after they receive their Cigna Medicare "Welcome Letter," as specified in the **Ready to Sell** section.
- All Agents must comply with any additional training requirements identified during the term of the agreement with Cigna Medicare.
- Telesales training will occur between September 1 and October 15 each year. Onsite and/or webinar training may be provided by Cigna Medicare at the time of initial setup and annually thereafter.

Initial Setup of New Telesales Agency

- An Agency onsite or virtual-site visit must occur prior to proceeding with implementation.
- Site visits will involve a complete assessment, which may include, but is not limited to, telesales operations, technical capabilities and compliance oversight.

- Any deficiencies identified during the site visit will be communicated to the Agency with required remediation. Time frames for completing remediation work will be agreed upon by both the Agency and Cigna Medicare. If remediation deadlines are not met, telephonic enrollment capability will not be granted.
- The Agency will be provided with copies of all applicable guidance (marketing, sales, etc.) that will need to be captured in policies and procedures.
- Agency will have to complete a Cigna Medicare IT review.

Telephone Systems

- An Agency must have a telephone system that can accurately route prospective customers to trained and qualified individual Agents who can appropriately handle calls.
- The telephone system must be able to transfer calls to a particular Agent as requested or needed. Live demonstration will be required during site visit.
- The telephone system should have the capability to do either silent or side-by-side monitoring of live calls. Live demonstration will be required during site visit.
- The telephone system must also have voicemail capability or administrative support to answer calls when a licensed Agent is not available. Agency must return the call within one business day. Live demonstration will be required during site visit.
- An Agency must be able to record all telephonic needs assessments, discussions, sales presentations and enrollments for the duration of the call, including internal transfers.
- An Agency must successfully complete testing prior to going live. Testing will include recording calls and successfully retrieving the stored data. Live demonstration will be required during site visit
- An Agency must be able to save recordings in a .WAV or .MP3 file using the following naming convention (live demonstration will be required during site visit).
  - Application calls should be saved as:
    - Customer's name_Agent's name_ YYYYMMDD_carrier name
  - Fact-finding calls (includes needs assessment and/or presale call) should be saved as:
    - Customer's name_Agent's name_YYYYMMDD_ carrier name_FF Part 1
    - Customer's name_Agent's name_YYYYMMDD_ carrier name_FF Part 2
    - Customer's name_Agent's name_YYYYMMDD_ carrier name_FF Part 3
  - Rewritten application calls should be saved as:
    - Customer's name_Agent's name_YYYYMMDD_ carrier name_re-enroll

Telephonic Recording Transfer and Storage Requirements

Cigna Medicare has two options available for providing recorded telesales calls. The telesales call recording ("Recording") must include the needs assessment, presale/sales presentation and the enrollment process. Failure to meet the outlined requirements may result in disciplinary or remediation actions.

For newly onboarded call centers, option 1 will be required for a probationary period of six months to ensure transfer timeline expectations and 100% call reconciliation can be met prior to allowing election of option 2.

Option 1 (standard):

- 100% of all Recordings must be posted to the Cigna Medicare secure FTP site within five (5) business days.
- Cigna Medicare will ensure the Recordings are stored for 10 years per CMS requirements.
- Agencies must notify Cigna Medicare of any changes to their Internet Protocol (IP) address.

Option 2 (requires approval):

- Agency is required to maintain all Recordings in accordance with the CMS records retention guidelines (minimum of 10 years).
- Agency is required to conduct self-audits to ensure 100% of telesales enrollments have Recordings on file. Agency must immediately report any reconciliation discrepancies to Cigna Medicare.

- Agency is required to provide five (5) Recordings for the first week of AEP.
  - Recordings must be uploaded to the Cigna Medicare secure FTP site within five (5) business days from the date of enrollment.
- Agency is required to provide Recordings as requested by Cigna Medicare for quality audits. The Cigna Medicare Sales Integrity team will identify the number of Recordings to be provided quarterly.
  - Agency will receive an email from Cigna outlining the Recordings to be provided.
  - Recordings are to be uploaded to the secure FTP site within five (5) business days of the request. Failure to provide the complete calls within the required time frame may result in Agency SDAP violation. Refer to the **Downgrade, Suspension and Termination** section for additional details and remediation requirements.
- For Agent complaints and CMS/Compliance requests, Agency is required to provide the Recording to Cigna Medicare via the secure FTP within the following time frames.
  - Urgent/immediate need CMS requests within 24 hours.
  - Standard request within five (5) business days.
  - Agency must have and provide a contact that will provide Recordings, and respond to urgent/immediate need CMS requests, within 24 hours, seven days a week.
- Agency is required to provide Recordings as requested for virtual ride-along reviews.
  - Agency is required to provide Recordings as requested by the Cigna Medicare Compliance team.
  - Agency will receive an email from the Client Service Manager outlining the Recordings to be uploaded to the secure FTP site.
  - Recordings are to be uploaded to the secure FTP site within five (5) business days of the request. Failure to provide the complete calls within the required time frame may result in Agency SDAP violations and remediation requirements.
- Agencies must notify Cigna Medicare of any changes to their Internet Protocol (IP) address.

Two failures to provide Recordings, based on the above requirements, may result in revocation of option 2.

Remote Telesales Agency Requirements

- Cigna Medicare may allow Agencies to have remote telesales Agents.
  - Agency must have sold telephonically with a physical location for at least one year with a proven track record with Cigna Medicare.
  - Agency must have a dedicated training staff that has sold telephonically and understands the nuances of selling over the phone.
  - Agency must be willing to accommodate in-house training for remote Agents not close to a physical call center location and the associated fees with flying a trainer to remote Agents for this purpose.
- Remote telesales Agencies/Agents must meet the same requirements as stated in **Telesales Agency Criteria**.
- Agency is required to have stand-alone supervisor or team lead available to remote telesales Agents by phone and/or instant messaging.
- Agency must demonstrate a robust training program tailored to Agents in a remote environment.
- Agency must provide documentation outlining their training program for remote telesales Agents.

Cigna Medicare may require updates or changes to this training program to comply with CMS and Cigna Medicare guidelines and will notify Agency in accordance to contractual obligations.

Remote Telesales Agent Requirements

- Remote telesales Agents must meet requirements as stated in the **Telephonic System** and the **Telephonic Recording Transfer and Storage Requirements** sections.
- Remote telesales Agents must train with seasoned telesales Agents using side-by-side listening sessions and role plays.
- Remote telesales is only permitted for seasoned or proven Agents with a clean compliance record.
- Prospective remote Agents must sit with a seasoned telesales Agent for a two-week probationary period in which the Agency will monitor calls and confirm the Agent can successfully and compliantly sell telephonically prior to being permitted to sell remotely. At the end of the two-week probationary period, the Agent must pass a telephonic Ride-Along

with a score of 85% or higher. Failure to pass this Ride-Along will result in denial of the request to sell remotely.

- Remote telesales Agents must only work from a secure location within the United States. Agency must maintain a list of addresses where Remote telesales Agents are based and ensure such locations are safe and appropriate.
  - If remote telesales Agents have print capability, they must have a locking file cabinet for storage and a shredder for destruction of materials that include PHI.
  - Remote telesales Agencies must create a separate remote workers' policy confirming adherence and compliant use, storage and disposal of Personally Identifiable Information (PII) and PHI as well as outlining how they track and monitor Agent compliance to this policy. Remote access to the Agency network must meet the same requirements outlined for in-house connectivity, including but not limited to, data loss prevention measures, multi-factor authentication utilization, and encryption in transit and at rest.

Hybrid Agent Guidelines

These guidelines are provided for Agents classified as "hybrid" and therefore looking to conduct sales via both field and telesales methods.

Guidelines

- Agents/Agencies are responsible for a clear understanding of all compliance and legal requirements for both field and telephonic sales.
- In order to be approved for hybrid Agent sub-delegation, Agencies must be delegated for field and telesales by completing Cigna's call center intake process. Any Agents designated as "hybrid" must be directly contracted under an approved field and telesales-delegated Agency.
- Agencies must demonstrate a robust training program tailored to Agents selling via both field and telesales methods. Agency must provide documentation outlining their training program for hybrid Agents. Cigna Medicare may require updates to this training program to comply with CMS and Cigna Medicare guidelines and will notify Agency in advance of these required updates or changes.

Face to Face

- When selling face to face, Agents must complete a full and compliant presentation, including a comprehensive needs assessment and full review of benefits.
- Agents must obtain a SOA prior to the presentation. Scopes must be retained for 10 years and provided upon request.
- If the customer wishes to enroll, Agent must use approved enrollment submission methods (see below).
  - Paper (fax or mail-in)
  - Cigna **e-Enrollment**
  - Third-party enrollment vendors – please work with your Cigna Medicare Agent Sales team for more information
- If data is being passed back and forth with these vendors, a Cigna Information Protection (CIP) review is needed to ensure data security. If written confirmation is provided that no data is being passed, no CIP review will be needed.
- Once the above have been provided, the third-party enrollment vendors must request approval from.
- Cigna Medicare to activate the Agent enrollment capabilities for Agency.
  - Enrollment files via SFTP (OEC) – please work with your Cigna Medicare Agent Sales team for more information.
- Agencies using OEC files for enrollment submissions must complete a Cigna Information Protection (CIP) review to ensure data security.
- OEC files must be tested prior to utilizing this sales method to ensure Cigna Medicare can accept and approve the enrollment types.

Telesales Guidelines

- When selling telephonically, Agent must use Agency's approved technology and call system.
  - Agent must perform a comprehensive needs assessment and review of health plan benefits in order for the potential customer to make an educated decision on enrollment into the plan.
  - Agent must follow CMS-approved scripts for both pre-enrollment and enrollment portions of the call.

- Enrollment requests are accepted only during an inbound telephone call from a potential customer.
- All portions of the call (needs assessment, pre-enrollment, enrollment, and any transfers between Agents or non-licensed reps) must be recorded and stored for 10 years per CMS guidelines.
- Upon completing a telephonic enrollment request, Agent must provide a confirmation number to the customer for tracking purposes.

Enrollment Submission Methods:

- Carrier platform (Salesforce).
- Third-party enrollment vendors – please work with your Cigna Medicare Agent Sales team for more information (see above).
- Enrollment files via sFTP (OEC) – please work with your Cigna Medicare Agent Sales team for more information (see above).
- Agencies must have P&Ps outlining these requirements and their process to oversee and monitor Agent compliance with these guidelines.
- These guidelines are intended to provide a general overview of Cigna Medicare telesales Agent conduct and compliance requirements. These are not inclusive of all of the state and federal laws, CMS regulations, company policies, or other requirements applicable to you.

SECTION VII

OVERSIGHT

Sales Development Action Program (SDAP)

The purpose of the SDAP is to address non-compliant incidents, as well as implement controls and evaluate marketing activities, quality improvement, and administrative aspects. The mission of the SDAP is to protect customers (potential and/or existing) and the organization from non-compliant sales activities.

Cigna implemented a disciplinary action program, which is managed by the Sales Integrity Unit. The SDAP is composed of senior leadership within Cigna and meets regularly to review potential Cigna and CMS policy violations. Policy violations may trigger a remediation/corrective action plan that must be completed accurately and in a timely manner. These corrective action plans can be triggered by the number of issues associated with an Agent or Agency or by a single egregious event. Remediation/corrective action plans may include, but are not limited to:

- Retraining
- A meeting with a Cigna representative to review the violation(s) and discuss policy requirement(s)
- Mock telephonic evaluations
- Secret shops
- Coaching
- Formal audit
- Financial penalty
- Suspension of selling activity, which must be reported to state and federal agencies.
  - Will not receive compensation and may not sell.
- Temporary hold of selling activities
  - If we determine an issue may threaten or damage Cigna's reputation or has the potential to harm our customers or does not meet our standards, we may place selling activities on "hold" until a complete investigation is finalized.
  - Still receive compensation; however, may not sell.
  - Not reported to state or federal agencies.
- Termination of contract
  - For Cause = applicable state and federal agencies may be contacted.
  - Not for Cause = no state or federal agency is contacted.

Marketing Materials and Scripts

Multi-Plan

On behalf of Agencies, their Agents and/or subcontractors, FDRs are required to submit all multi-plan materials used to market Medicare plans on behalf of multiple carriers directly to CMS. Multi-plan materials must be submitted to CMS via the HPMS by only those individuals within the FDR Cigna has authorized to do so. Materials must also be approved by CMS prior to use. Please note, Cigna can no longer submit multi-plan marketing materials to CMS on behalf of an Agency.

Cigna Branded

Materials created using the Cigna brand or to market solely Cigna Medicare plans must be submitted directly to Cigna for review and approval. Upon review and approval, Cigna will submit the materials directly to CMS if materials submitted provide plan benefit information that is open to the customer. If they are Agent-facing materials only, they would not be sent to CMS for approval.

Inbound and Outbound Scripts

In contacting beneficiaries on behalf of Cigna, scripts used by certified Agents authorized to conduct telephonic sales and marketing activities should be forwarded to Cigna for review. Upon completion of its review, Cigna will forward all scripts to CMS for final review and approval. CMS approval of all scripts is necessary prior to use. Note that these review can take up to 45 days once submitted to CMS.

During telephonic sales presentations, Agencies/Agents must verbally provide instruction on where to locate the appropriate summary of benefits to the customer. It is important to provide this information regarding Cigna plans to all potential customers to ensure they understand the plan they are enrolling in and are making an informed decision. Failure to meet these requirements will result in an SDAP at the Agent level and potentially the Agency level.

In addition, when conducting outbound calls, scripts must include a privacy statement clarifying the customer is not required to provide any health-related information to Cigna or Agent and that the information provided will in no way affect the customer's membership in the MA/MAPD Plan. Please refer to Cigna's *Medicare Sales Policies Handbook* and to CMS guidelines for additional guidance.

SECTION VIII

OPERATIONAL REQUIREMENTS

Business Reply Cards (BRC) and Scope of Appointment (SOA)

BRC Guidance

BRCs must be approved by and submitted to CMS if benefits/cost information or plan information is mentioned, or if the BRC is to be used as an agreement to be contacted, confirmation of a sales or marketing event, or a request for more information. BRCs must include a statement informing the beneficiary that an Agent may call them as a result of returning a BRC. Please see **Marketing Materials and Scripts** section for specific details.

SOA Guidance

All Agents conducting one-on-one appointments with beneficiaries regardless of the venue (e.g., in home, by phone or at a library) must follow the SOA guidance, complete an SOA in advance when practicable and **must**:

- All SOA forms approved by Cigna prior to use.
- Clearly identify products before marketing to a potential customer and the customer must agree to the scope of the appointment and such agreement must be documented by the Agent.
- Provide adequate documentation, so telephonic appointments must include a recorded SOA.
- All SOAs for a period of ten (10) years, in accordance with state and federal regulations. Evidence of the SOA, including the disclaimer language, must be submitted to Cigna upon request.
- Not discuss additional products unless the customer requests the information. Any additional lines of business that are not identified prior to the in-home appointment will require a separate SOA.

Independent Agents are no longer required to submit a paper SOA to Cigna.

Compliance

- Submitted SOAs will be reviewed for compliance, and five non-compliant SOAs will incur a violation
- Un submitted SOAs may also be requested by Cigna, and the Agent may incur a violation after five incidents of either a non-compliant SOA or inability to produce an SOA

For further guidance, please refer to Cigna's job aids available on **Producers' University**. Once signed in, search for keywords **Business Reply Card, BRC, Scope of Appointment, SOA**, or follow these direct links:

BRC	SOA
Cigna Digital BRCs Webex Training Session Recording	Scope of Appointment Job Aid
Online BRC FAQ-Broker Only	Scope of Appointment (SOA) Scenarios-External Brokers
Using the Personalized Online BRC	Virtual Scope of Appointment
Compliant Business Reply Cards	eScope Quickstart

Required Disclosure

Agents must provide the following disclosure, or a substantially similar disclosure, prior to enrollment or at the time of enrollment, in writing, to a potential customer:

"The person that is discussing plan options with you is either employed by or contracted with Cigna and its applicable affiliates offering Medicare Advantage and/or Medicare Part D plans. The person may be compensated based on your enrollment in a plan."

Additional disclosures and disclaimers may be required. Please contact Cigna for assistance.

Individual Leads

Cigna Medicare may, at its sole discretion, supply overflow leads to Agency, Subordinate Agency or Agent. However, Cigna Medicare is not responsible for supporting the Agency with leads or financial support in their prospecting efforts. During a visit with the prospect, Agency, Subordinate Agency or Agent can present the Cigna Medicare Advantage products with full disclosure and enroll the prospect. Referrals may only be obtained in accordance with Cigna Medicare policy and CMS guidelines. Agency, Subordinate Agency or Agents must follow all guidelines and regulations that govern the proper procedure for prospecting and selling Cigna Medicare products, including all requirements set forth under MIPPA and the CMS MCMG.

Submission of Enrollment Applications

It is important to fill out the enrollment application completely and accurately in order to avoid processing delays and possible rejection of the enrollment. There are multiple methods Agents can use to submit enrollment requests to Cigna Medicare. Valid Cigna Medicare submission methods are as follows.

eEnrollment

The Cigna Medicare eEnrollment form is a paperless electronic application accessible via **https://broker.hsconnectonline.com**.

The eEnrollment form:

- Is available via laptop and tablet browsers.
- Is an internet application accessed through a web browser.
- Creates a complete application that can be verified and signed before submission.
- Allows the Agent/customer to submit a completed application immediately for processing.

Paper Application

Each completed paper enrollment must be faxed to the appropriate Cigna Medicare regional enrollment fax number, using the appropriate Application Cover Sheet as the first page of each enrollment, within two (2) calendar days of the signature date.

The customer may send the application directly to Cigna Medicare by mail or fax; the date received will be the office application receipt date. Applications sent by mail that do not meet the two calendar-day time frame will result in an SDAP violation for application timeliness.

For telephonic enrollments, the office application receipt date is the date of the call. To confirm receipt of faxed applications, an Agent can use **Cigna for Brokers** or call **CARL**.

Cigna for Brokers

Contracted and approved telesales Agents may use the telephonic enrollment script on Cigna for Brokers via **www.cignaforbrokers.com** to submit enrollment requests.

In the event a telesales Agency/Agent does not use the telephonic enrollment script on **Cigna for Brokers**, enrollments over the phone must be accepted by approved telephonic enrollment mechanisms and follow the approved enrollment script.

For more information on Agent resources; please refer to the following guides once logged into **Producers' University**:

- **Site Credentials**
- **Quick Guide**

Safeguard Information

Safeguard information when it is moved.

- Ensure Cigna information that is saved to non-Cigna equipment, such as a home PC, tablet or smartphone, is encrypted.
- Double-check for correct recipients and addresses before mailing and faxing information.

Protect paper documents.

- When away from the desk for an extended time, lock restricted information away and remove the keys. For highly sensitive information, lock it away any time the area is left.
- Discard paper documents in locked shred bins.
- Retrieve confidential documents at the printer or fax machine immediately.
- Files in any medium (paper, disk, CD) containing Highly Sensitive or Restricted information must be carried in a locked or secured pouch (such as a sealed envelope or closed briefcase) when transported between work locations.

Secure computer and passwords.

- "Lock" computer using Ctrl + Alt + Delete > Enter (or the Windows key + L) every time it will be left unattended.
- Passwords, PINs, or other security access codes will not be stored with or attached to the laptop or device.

Agencies must report incidents to Cigna when information has been misdirected.

Supporting Documentation

Power of Attorney

When applicable, a customer may state on the election form that they have a Power of Attorney. In order to accept Power of Attorney for a customer, copies of the executed legal document must be attached to the application. The Power of Attorney will state the person's name and may include relationship to customer. The Power of Attorney will be able to act on their behalf should they become incapacitated. The Power of Attorney document should indicate that it is for medical reasons.

Required Documentation Includes:

- Name(s) of each Power of Attorney
- Relationship to customer if known
- Initials of person entering the data
- Department of person entering data

Request for Information

RFI notification will be sent from Cigna when an application is received that is missing or requires additional information. The email will include the following information:

- Details regarding the specific issue.
- What is needed to continue processing the application.
- How to submit the information.

- Due date to receive the information to prevent the application from being denied.
  - There are many rules surrounding the deadlines for RFIs, but typically customers have **21** days from the date of their RFI to send the required information.

Helpful Tips

- Agent should not submit a new application, unless advised to do so, while an RFI is active.
  - Usually another application does not solve the issue and only creates a duplicate enrollment while keeping the current application in an RFI status.
- If at any time an Agent has questions, they should reach out to **CARL**.

Application Submission Policies and Timeliness

CMS has strict regulations regarding the submission of enrollment applications. Per Cigna Medicare policy, Agents have two calendar days to submit the completed application form to Cigna Medicare. The two calendar-day window is applicable regardless of the day of the week the completed form was accepted from the customer. The two-day rule applies for enrollments throughout the year, including AEP. **If the customer insists on sending the application via mail, the Agent should not sign or date the Agent portion of the application. The Agent should also inform the customer not to fill in this section at any time.** Enrollments accepted over the phone must be accepted by approved telephonic enrollment mechanisms and follow the approved enrollment script. Telephonic applications must list the date of the call as the application date.

Checklist for Application Process:

Confirm eligibility requirements.

- Customer must have Medicare Part A and Part B to join a Medicare Advantage plan, and the customer must also have Medicare Part D to join a Medicare Advantage Prescription Drug Plan.
- Customer must reside in the approved Service Area for their selected plan.
- Customer must have active Medicaid if applying for a Total Care plan, and the Agent should include proof of active Medicaid in the application submission when possible.

It's recommended that the Agent secure Medicaid eligibility status information for all customers completing an enrollment request and include the active Medicaid ID on the form if applicable.

Please note that Agents are required to follow all CMS application requirements in the MMCM Chapter 2 – Medicare Advantage Enrollment & Disenrollment Guidance.

Application Resource: Enrollment Period Guide

Application Checklist

Application Must Include	
Customer's Plan Choice	Other Prescription Drug Coverage Question
Medicare Insurance Information	Long-Term Care Facility Question
Customer's: › DOB › Gender › Phone Number › Permanent Address/Mailing Address › PCP Full Name	State Medicaid Program Question
Premium Payment Option	Multi-Language/Print Necessities
Prescription Drug Coverage Information	Signature of Applicant/Customer/Authorized Representative
Additional Medical Health Coverage Information	Checklist for Special Enrollment Period Eligibility

Enrollment Application Cancellations, Withdrawals

Cancellation/Withdrawal

If a customer wishes to cancel or withdraw an application, they must send a letter to Cigna Medicare or call Customer Service prior to the effective date.

Please note that cancellations must be completed before the effective date, and disenrollment requests must be completed after the effective date with a written and valid reason for disenrollment.

SECTION IX

COMPENSATION RULES

Commission Department Services

The Commission Department exists to process new application, chargeback, CMS reconciliation and renewal commission payments, as well as to provide service to the Agent and Agency partners surrounding these payments.

Any inquiries to the Commission Department should be sent from the partner through secure messaging via Cigna's secure web portal or another secure portal utilized by the partner. Inquiries are very important to the Commission Department, and all inquiries will receive a response within three business days of receipt, except during high-volume periods such as following the January renewal payment and the January 1 new sales pay cycles. All commission inquiries should be made to **CARL**.

All commission statements outline the activity which has occurred within the given pay period for each producer.

Note: This document does not apply to stand-alone PDP.

New Application Payments

Per CMS guidelines, Cigna defines a compensation year as January through December (a normal calendar year). Cigna is required to pay Agents at compensation rates within ranges filed and attested annually with CMS. Agents on an Assignment of Commissions (AOC) must similarly be paid by the Assignee unless a compliant compensation plan is submitted with documented approval from Cigna. More-specific compensation information can be found in the "2022 Cigna Compensation Rate Schedule."

Enrollments must be a result of the direct contact between the Agent and the individual prospect. Cigna will pay a commission for each individual whom Agency or Subordinate Agency or Agents enroll in a Cigna MA/MAPD plan. Agent-level commissions and Agency admin fees for new applications are paid per the current commission schedule set forth annually (see "2022 Cigna Compensation Rate Schedule"). Payments will be made during the normal commission payment schedule as set forth by Cigna policy unless otherwise agreed between the parties.

To be eligible to receive Agent-level commission payments/Agency admin fees from Cigna, both the writing Agent and Agency must be properly contracted, licensed and appointed (based on each state's regulations) prior to making a sale. Writing Agents are also required to complete annual training/certification requirements prior to making a sale, per CMS. If the writing Agent is noncompliant, payment will not be administered to any party, including the hierarchy, for the applicable enrollment.

In the event an Agency is noncompliant (i.e., is not properly contracted, licensed and appointed, and/or has not completed required attestation), that Agency will not receive a payment but all other compliant entities in the hierarchy may receive payment. Cigna payments on new applications are made per the schedule set forth in the 2022 Cigna Compensation Rate Schedule and also located on **Producers' University**. In addition, payments are made based on the contracting and hierarchy in place at the time of sale. Cigna Medicare endeavors to process payments for new applications within two or three weeks of submission. Payment may be delayed if the Agent's correct alphanumeric writing ID is not included on the customer's enrollment application or if required information is missing from the application.

The above requirements must be maintained for all subsequent renewal years for the Agent and Agency to continue receiving renewal payments (see section entitled **Renewal Compensation – Prior Effective Years** for more information).

Cigna identifies three potential compensation scenarios for new enrollments to Cigna.

1. **Initial Year, No Prior Plan** – A customer identified by CMS via monthly CMS Compensation reporting to be in their Initial Compensation year in a MA or MAPD plan with no reported prior plan. These enrollments are eligible for a full, initial compensation rate payment (12 months). This includes Agent-level commissions and Agency admin fees.
2. **Initial Year, Prior Plan** – A customer identified by CMS via monthly CMS Compensation reporting to be in their Initial Compensation year in a MA or MAPD plan coming to Cigna from a like plan type (another MA/MAPD carrier) or non-like plan (PDP, PACE, COST). For example, a customer ages into Medicare in March, enrolls with a different carrier, then moves out of the service area and subsequently enrolls with Cigna in September. These enrollments are eligible for payment at initial compensation rates.

Agent-level commissions will be prorated based on how many months the customer is anticipated to be enrolled in a Cigna plan during the compensation year. For example, an enrollment effective January 1 will receive the full, initial compensation rate (12 months) as the customer is expected to be enrolled for the full compensation year; however, an enrollment effective April 1 will receive 9/12 of the initial compensation rate as the customer is expected to be enrolled for nine months of the compensation year.

Agency Admin fees will be paid at the full, initial compensation rate (i.e., 12 months) regardless of the number of months the customer is expected to be enrolled in the current plan year.

3. **Renewal Year Enrollment** – A customer identified by CMS via monthly CMS compensation reporting to be in a Renewal Compensation year. For example, a customer coming from another carrier enrolls with Cigna during AEP for January 1, 2022, effective date. These customers have been enrolled in a plan for at least one full compensation year and thus are only eligible for payment at renewal compensation rates.

   Agent-level commissions will be prorated based on how many months the customer is anticipated to be enrolled in a Cigna plan during the compensation year. For example, an enrollment effective January 1 will receive the full renewal compensation rate (12 months) as the customer is expected to be enrolled for the full compensation year; however, an enrollment effective February 1 will receive 11/12 of the renewal compensation rate as the customer is expected to be enrolled for 11 months of the compensation year.

   Cigna will pay Agency administrative fees at the full renewal compensation rate (i.e., 12 months) regardless of the number of months the customer is expected to be enrolled in the current plan year.

   New to Cigna Exception: Cigna will pay Agency administrative fees at the full initial compensation rates if the customer meets "New to Cigna" criteria even if the customer is identified by CMS as being in a Renewal Compensation year.

   New to Cigna customers are identified as:

   - A Customer that has not been actively enrolled for the previous 12+ months.

This policy **only** applies to administrative fees paid to properly contracted, licensed and appointed GA, MGA, SGA or FMO Agencies. This is a one-time payment to be made on the initial sale (normal chargeback rules apply), and Cigna may discontinue this policy at any time at its discretion.

Note: This payment policy does **not** apply to Cigna customers enrolled in Leon plans in Miami-Dade County.

Initial Year Agent Commission Examples

Initial Year Agent Commission Examples: Rates based on all markets except DC/PA and NJ.

Enrollment Type	Effective Date	Prior Plan	First Payment	CMS Recon Payment	Total Paid
Initial Year	1/1/2021	NONE	$270	$269	$539
Initial Year	1/1/2021	PDP, PACE, COST	$270	$269	$539
Initial Year	4/1/2021	NONE	$202.50	$336.50	$539
Initial Year	4/1/2021	MA/MAPD, PDP, PACE, COST	$202.50	$201.75	$404.25
Initial Year	7/1/2021	NONE	$135	$404	$539
Initial Year	7/1/2021	MA/MAPD, PDP, PACE, COST	$135	$134.50	$269.50

Example for illustrative purposes only.

Due to the timing of the monthly CMS Compensation Reporting, all enrollments will be paid at the renewal compensation rate. The Agent-level renewal compensation rate will be prorated based on the number of months the customer is anticipated to be enrolled with Cigna during the compensation year as stated in the section above. On receipt of the monthly CMS Compensation Report, Cigna will perform an audit and compensate Agents/Agencies for any additional payments owed on initial-year customers. This payment is called the CMS Reconciliation (True Up) payment and it is made on a monthly basis. Please note: It may take six to eight weeks for Agents/Agencies to receive CMS Reconciliation (True Up) payments after an application has been submitted.

Compensation Recovery – Chargebacks

Upon the termination of a customer's continuous enrollment with Cigna, all payments (including Agent-level commissions and Agency admin fees) made for 2022 effective applications will be subject to either a full or prorated chargeback based on the following.

A Full Chargeback Will Be Recovered If:

- The customer makes any plan change within the first three months of enrollment, including disenrollment, that does not qualify for a rapid disenrollment exception as outlined by CMS. For example: The customer becomes LIS or dual (Medicare and Medicaid) eligible and qualifies for another plan based on special needs.
- The customer enrolls for October 1, November 1 or December 1 and disenrolls from the plan (unrelated to AEP).
- The customer terminates prior to enrollment for any reason (cancellation).

A Prorated Chargeback Will Be Recovered If:

- The customer makes any plan change within the first three months of enrollment, including disenrollment, that does not qualify for a rapid disenrollment exception as outlined by CMS. For example: The customer becomes LIS or dual (Medicare and Medicaid) eligible and qualifies for another plan based on special needs.
- The customer enrolls in a new plan with a new Agent (external) after the rapid disenrollment period; the prior Agent will no longer continue to receive compensation and would incur a prorated chargeback for any unearned months.
- The customer terminates after the rapid disenrollment period but prior to December 31 in the 2022 calendar year. This includes scenarios where a customer might move from one carrier to another, or when a customer moves from one plan to another within the same carrier.

Note: In the event an Agent is paid at the full, initial compensation rate for an enrollment with an effective date after January 1, Cigna would be required to chargeback compensation previously paid for all months that customer is not on a Cigna plan. For example, if a customer enrolls May 1 and disenrolls August 31, Cigna will chargeback commissions/admin fees not only for September 1 through December 31 but also for January 1 through April 30, or the eight months that the customer was not enrolled in a Cigna plan.

Retroactive Chargebacks

If Cigna is notified of a retroactive customer disenrollment, full or prorated chargebacks will be issued accordingly, depending on the disenrollment scenario as outlined in the previous section. Retroactive chargebacks will also be issued in the event a customer's disenrollment was not processed in a timely manner by the Commission Department. For example, a customer disenrolls December 31, 2021, but the Commission Department is not notified of the change in enrollment status until after the 2022 plan year has already begun, resulting in the payment of 2022 renewals. In this scenario, all compensation paid for the 2022 plan year would be charged back.

Agent Change Scenarios

In the event of an Agent change, prorated chargebacks will be issued to the original Agent and hierarchy for unearned months. The new Agent will be paid commissions going forward based on the effective date of the change.

Valid Agent change scenarios include, but are not limited to, the following:

- An existing Cigna customer is enrolled in a new plan by another Agent. For example, a customer is enrolled in Plan 1 effective January 1, 2022, by Agent A and is then enrolled in Plan 2 effective July 1, 2022, by Agent B.
  In this scenario, Agent A would no longer be the AOR effective July 1, 2022, and would incur chargebacks equal to six months of commissions (July through December). Agent B would be paid six months of commissions (July through December).

Note: If a plan change is performed by the CARL Plan Change Unit, the current AOR will be retained and no chargebacks will be issued. The current AOR would also be retained if an internal Cigna Agent performs a plan change.

- A customer terminates their enrollment with Cigna and then re-enrolls with another Agent at a later time. For example, a customer disenrolls effective December 31, 2020, and then re-enrolls effective January 1, 2022, with a new Agent. In this scenario, there is a break in coverage, during which time the customer was not enrolled with Cigna.

- A customer voluntarily disenrolls with Cigna during AEP, enrolls with another carrier and then decides to return to Cigna without a break in coverage. For example, a Cigna customer disenrolls effective December 31, 2021, and then chooses to re-enroll effective January 1, 2022, with a new Agent.
- A Cigna customer converts from an MAPD plan to an MMP plan and then later re-enrolls in MAPD with a new Agent. For example, a customer enrolls in an MAPD plan effective January 1, 2022, with Agent A, moves into an MMP plan effective April 1, 2022 and then re-enrolls in MAPD effective January 1, 2023, with Agent B.

Plan Change Scenarios

In the event a plan change is submitted for an existing Cigna customer and there is no break in coverage, compensation will be impacted as follows:

- If an Agent submits a plan change for an actively enrolled Cigna customer already in the Agent's own Book of Business (BOB), it will be treated like a new application. Since new application payments are made based on the contracting/hierarchy in place at the time of sale, Agent-level commissions and Agency admin fees may be impacted if the Agent has experienced a contracting/hierarchy change. Please refer to the **New Application Payments** section of this document for more information, including Agent/Agency requirements for payment.

In the event a mid-year plan change is submitted, Agent-level commissions and Agency admin fees will be charged back and subsequently repaid (where applicable) based on the new plan change effective date. For example, if an August 1 effective plan change is submitted for a January 1 effective customer, chargebacks will be issued for August through December (five months). Agent-level commissions and Agency admin fees would then be repaid (where applicable) based on the new plan change application submitted. If a CMS True Up is owed, the new application payment and the CMS Reconciliation (True Up) payment may be paid separately.

Note: This does not apply to Cigna Legacy Arizona business. If the existing AOR submits a plan change for a Cigna Legacy Arizona customer, there will be no impact to Agent-level commissions or Agency admin fees (i.e., no chargebacks and/or additional new application payments will be issued).

- If an existing Cigna customer is enrolled in a new plan by a new external Agent, the AOR will change as of the new enrollment effective date. For example, a customer is enrolled in Plan 1 effective January 1, 2022, by Agent A and is then enrolled in Plan 2 effective July 1, 2022, by Agent B. In this scenario, Agent A will no longer be the AOR effective July 1, 2022, and will incur chargebacks equal to six months of commissions (July through December). Agent B will be paid six months of commissions (July through December).

Note: If a plan change is performed by the CARL Plan Change Unit, the current AOR will be retained and no chargebacks will be issued. The current AOR would also be retained if an internal Cigna Agent performs a plan change.

- In the event a plan change is submitted for an existing Cigna customer within the first three months of enrollment (rapid disenrollment period), Agent-level commissions and Agency admin fees will be charged back in full. However, if the plan change qualifies for a rapid disenrollment exception as outlined by CMS, prorated chargebacks will be issued.

Renewal Compensation – Prior Effective Years

- All active customer enrollments from prior effective years will begin the next renewal cycle in January 2022. Renewal compensation will be paid based on the contracting and hierarchy in place at the time of sale. Agent-level renewal compensation will be paid at 2022 Fair Market Value (FMV). The FMV for 2022 renewals can be found in the Compensation Rate Schedule. Agency admin fees will be paid based on historical renewal rates in place at the time the customer was enrolled.

Note: Agency admin fees for customers originally enrolled under a Cigna Legacy Arizona contract will be paid based on 2022 renewal compensation rates.

- To be eligible to receive renewal compensation from Cigna, both the Agent and Agency must be actively contracted, licensed and appointed (based on each state's regulations). Writing Agents are also required to complete the next year's training/certification requirements prior to December 31 of the current plan year. For example, 2022 training/certification must be completed by December 31, 2021, to receive

Agent-level renewal compensation. Agencies must also complete annual attestation requirements by March 31, 2022, to receive renewal compensation for the 2022 plan year. Renewal compensation will not be paid until the annual attestation requirement has been completed.

In the event an Agent/Agency is noncompliant (i.e., is not properly contracted, licensed and appointed and/or has not completed required training/attestation by the previously mentioned due dates), all current and future renewal compensation for their existing Book of Business (BOB) will be forfeited (i.e., a payment will not be received). All other compliant entities in the hierarchy will receive payment.

- Agencies that have been downgraded from a GA, MGA, SGA or FMO to a personal business entity are not eligible to receive Agency admin fees. Therefore, a renewal payment would not be received for the Agency's existing BOB written under their prior GA, MGA, SGA or FMO contract with Cigna.
- Renewal compensation will be paid in January of the calendar year following the initial enrollment effective date providing all validation requirements are met (i.e., active Cigna contract, license and appointment and completed certification/attestation). For example, renewal compensation for customers that have a March 1 effective date will be paid in January of the following calendar year.
- All renewal compensation will be paid on an up-front, lump-sum basis for continuously enrolled customers. Cigna will process renewal disenrollment chargebacks for the months remaining in 2022 following a customer's termination date.
- Upon termination of a customer's continuous enrollment, all renewal payments made in 2022 will be subject to a full or prorated chargeback. A prorated chargeback will be recovered if the customer terminates January 31 through November 30 in the 2022 calendar year.
  - For example, a prior effective year customer with a June 30, 2022, termination date will result in a chargeback of 6/12 of the January renewal payment, keeping the Agent/Agency whole for the six months (January through June) in which the customer was enrolled in the plan.
- When a customer enrolls in a new "like plan" with a new Agent (external), it will result in a change of the servicing Agent, therefore considered a commissionable event. A commissionable event is not initiated if a beneficiary calls the CARL Plan Change Unit to make a plan change. In this situation, the original Agent will remain the servicing Agent and therefore retain commissions as long as the customer remains enrolled (providing all required Agent validations are met).
- When an Agent retires or becomes disabled, he or she will become inactive and will no longer qualify to receive commission payments of any type. To continue to receive future commission payments, the Agent must recertify annually, maintain applicable state licensure, and remain actively contracted and appointed with Cigna. In the case of an Agent's death, Cigna will determine if the Agent's future renewal commissions may be assigned to the Agent's spouse or business partner (please see section detailing requirements for a **Deceased Agent Active Commissionable Book of Business Transfer**). If such assignment is permissible, the spouse/business partner must be licensed and appointed in all relevant states, complete annual certification requirements, and become otherwise contracted with Cigna.
- In the event an Independent Agent moves to a Cigna employee contract, all future Agent-level renewal compensation will be forfeited for their BOB written as an Independent Agent.

Cigna Does Not Compensate an Agent/Agency for the Following Reasons:

- When an application is rejected, denied, cancelled or voided.
- When an application is incomplete or in RFI status and the request for additional information is not met within the required time frame.
- When an Agent is in terminated or suspended status.
- When an Agent/Agency is deemed unqualified due to lack of contract, license, appointment and/or certification/attestation.

Compensation Schedule Guidelines

All compensation for 2022 effective applications will be paid at the 2022 compensation rates indicated in the compensation rate schedule. Agent-level compensation for all eligible renewing customers will also be paid

based on the 2022 compensation rates, regardless of original effective year. Agency admin fees for renewing customers will be paid based on historical renewal compensation rates in place at the time the customer was originally enrolled; however, if the historical renewal compensation rates exceed the amounts allowable in the current year as published by CMS, the renewal compensation will be automatically adjusted to comply with applicable law.

Note: Agency admin fees for customers originally enrolled under a Cigna Legacy Arizona contract will be paid based on 2022 renewal compensation rates.

While Cigna intends to pay all Agents/Agencies the highest commission rate within the ranges filed with CMS, Cigna reserves the right to change an Agent/Agency's specific commission rate to an amount within each range for any reason and at any time, at Cigna's sole discretion. Cigna will make best efforts to advise an Agent/Agency of any change to their commission rate in advance of the effective date of such a change.

Per CMS, Initial Compensation is paid only when the beneficiary is a new enrollee to Medicare or MA/MAPD, as validated by the CMS Compensation Reports. All compensation will be paid as renewal compensation unless CMS Compensation Reports indicate the compensation should be Initial Compensation. In addition, compensation will not be received until CMS approves the customer's enrollment.

All Agents will be compensated by Cigna at the rates indicated unless an alternative MIPPA-compliant compensation plan is submitted with the documented approval from Cigna. For enrollments with effective dates in the 2022 calendar year, Compensation Rate Schedules can be located on **Producers' University**.

Payments

Non-Exclusive Agents

Per CMS Compensation Guidance, Cigna is required to compensate Independent Agents for all valid 2022 commissionable transactions, including those for 2022 effective enrollments and all renewing customers, within the 2022 Plan Year (January 1, 2022, through December 31, 2022). Cigna cannot compensate an Independent Agent prior to January 1, 2022, for any 2022 enrollment and must complete compensation for all 2022 eligible enrollments by December 31, 2022.

Cigna will only release payment for new 2022 effective applications written during AEP to Agents/Agencies who are actively contracted with Cigna at the time of payment. Additional requirements for new application payments are outlined in the **New Application Payments** section of this document. In the event an Agent/Agency is not actively contracted with Cigna at the time of payment, compensation will be forfeited (i.e., a payment will not be received).

Exclusive Agents

Agents who are captive to Cigna will continue to be compensated on a weekly basis for approved 2022 effective applications submitted during AEP, or as otherwise set forth in their contract with Cigna. CMS true-up payments for qualifying new-to-Medicare customers with 2022 effective dates will be paid in January. Cigna will complete compensation for all 2022 eligible enrollments by December 31, 2022.

Payments for All Agents

After January 1, 2022, Cigna will begin to compensate all Agents on a weekly basis for all 2022 effective date applications submitted that result in Cigna customers.

After January 1, 2022, Cigna will begin to compensate all Agents on a monthly basis for CMS Reconciliation payments on enrollments eligible to receive full or prorated initial compensation.

Regardless of original effective date, all active customer enrollments from prior effective years (if applicable) will begin the next renewal cycle in January 2022. All Agent-level renewal compensation will be paid at current compensation plan year Fair Market Value (FMV). FMV for 2022 renewals can be found in the Compensation Rate Schedule.

Compensation Statements

During pay periods in which an Agent or Agency has transactions (new application, chargeback, CMS reconciliation or renewal records), a commission statement will be generated. Cigna Medicare statements are emailed to all producers via secure email from the Commission Department. Arizona Agents/Agencies can access commission statements for business written under a Cigna Legacy Arizona contract within the EvolveNXT Agent portal. These statements are not emailed unless requested from **CARL**.

Currently, Cigna uses Proofpoint as the secure email site. Registration to this site (login and password)

is required to access Cigna statements. Agents or Agencies that have trouble opening their statements through the secured Proofpoint system should contact **CARL**.

Outstanding Receivables

In the event Cigna makes an overpayment of compensation to an Agent/Agency for any reason, chargebacks will be issued. All chargebacks will be identified on relevant commission statements and will be offset by new earnings. In the event an Agent/Agency does not have enough new earnings on a particular pay cycle to satisfy all chargebacks issued, no payment will be made and the commission statement will indicate a negative ending balance (also known as an outstanding receivable). Any new earnings on subsequent pay cycles will go toward satisfying the outstanding receivable. Cigna also reserves the right to recover outstanding receivables from earnings across all Cigna.

On request, an Agent/Agency with an outstanding receivable shall remit payment to Cigna in full or establish an approved payment plan. If payment is not remitted in a timely manner, Cigna may engage a collection agency. The Agent/Agency will be responsible for reimbursing all expenses incurred by Cigna, including but not limited to, collection agency and/or legal fees. Agencies must also utilize best efforts to assist Cigna in recovering overpayments from any of its Subordinate Agents.

Assignment of Commissions (AOC)

The AOC document defines how an Agent-level commission is paid at the time a customer is enrolled, and for all future renewal payments on that enrollee, should the customer remain enrolled with Cigna. The AOC directs current and renewal Agent-level commissions related to the specific customer to the direct Upline Agency (Assignee).

The AOC only pertains to business written as of the day the agreement is signed. If there is an AOC in place at the time of sale and the Agent is later released to be paid directly and/or to move under a new hierarchy, all renewal payments for existing customers will continue to be made under the AOC agreement in place at the time of sale. Similarly if an Agent moves from direct pay to an AOC, Agent-level renewal payments for existing customers will continue to be paid to the Agent directly.

Assigning Commissions to a Personal Business Entity

Writing Agents may assign their commissions to a personal business entity that does not qualify as a GA, MGA, SGA or FMO. The entity must have its own tax ID and all applicable state licenses and appointments (based on each state's requirements). Only the Agent that owns the personal business entity and his or her spouse or partner may assign commissions to the entity. The personal business entity does not qualify for Agency admin fees.

To assign commissions to a personal business entity, the Agent must submit an AOC form naming the entity and complete a W9 that includes the entity's business name, tax classification and tax ID. Per the previous section, the AOC only pertains to business written as of the day the agreement is signed. Agent-level commissions previously assigned to an Upline Agency (Assignee) would not be impacted.

In the event a personal business entity is upgraded to a GA, MGA, SGA or FMO, the Agency would only receive Agency admin fees for new business written going forward. Business written while the Agency was contracted as a personal business entity would not be eligible for Agency admin fees.

If a personal business entity fails to maintain applicable state licenses and appointments, all Agent-level commissions falling under the AOC will be forfeited.

Agreement to Service the Member (ASM)

Definition

An executed document between the Assignee Agency and Cigna whereby the Assignee agrees to properly service the Cigna customer in the event of a Subordinate Agent becoming inactive with Cigna. A Subordinate Agent may become inactive as a result of the Agent's termination by Cigna, leaving Cigna's service area or termination of the Agent's participation in the Medicare Advantage Program. Termination may be due to a variety of reasons, including failure to certify by December 31 for the upcoming plan year, cancelled/expired licensure, death, retirement, etc.

When a Subordinate Agent becomes inactive with Cigna, he or she no longer qualifies for compensation because CMS only allows Cigna to release Agent-level commission payments if an Agent is actively licensed, appointed and certified. In the case of an AOC, the ASM demonstrates that there is a new Agent within

the Assignee Agency's organization dedicated to the service of that customer (AOR). An AOC must be in place for the ASM to be valid.

* The ASM document does not apply to PDP or Cigna Legacy Arizona business.

Policy

General requirements for the ASM are as follows:

- The ASM only applies to enrollments being paid under an AOC that are associated with the Assignee Agency. This includes new enrollments submitted by the Subordinate Agent during AEP for the upcoming plan year, in the event the Subordinate Agent becomes inactive with Cigna prior to commissions being paid.
- The ASM only applies in scenarios where the Agent's entire Book of Business is impacted. It would not be applied in a scenario where only one state or product is impacted. For example, the ASM will not be applied in the event an Agent fails to maintain licensing requirements in one specific state and has existing Cigna MA/MAPD business in multiple states.
- The ASM does not apply to enrollments for which the original Agent was being paid directly, nor does it apply to enrollments the Agent previously submitted under a different hierarchy (i.e., business written independent of the Assignee Agency). The ASM also does not apply to enrollments where the original Agent has been deemed unqualified due to lack of contract, license, appointment and/or certification at the time of sale.
- The ASM is effective the day it is received, unless otherwise noted by Cigna.
- The ASM only applies to Agents who are inactivated after the document has been received and approved by Cigna.
- If the original writing Agent fails validations and an ASM is not already in place, Agent-level commissions will be forfeited for the affected Book of Business; submitting an ASM at a later date will not restore Agent-level commissions. Agency admin fees would not be impacted providing Agency validation requirements are met (i.e., active Cigna contract, license and appointment, and completed attestation).
- If the original Agent was contracted for Field sales, the Assignee Agency will be required to notify all affected active customers of the change in representation. The Assignee Agency will retain customer notification documents and will provide to Cigna on request in the event of an audit.

Changes to the Designated Agent on the ASM Document

In the event the designated AOR on the ASM document is being terminated, or otherwise becoming inactive with Cigna, a new ASM document must be submitted prior to the Agent's termination date (i.e., within 30 days of the date on term letter received) or Agent-level commissions will be forfeited.

In the event of the designated Agent's death, Cigna requires notification, as well as a new ASM document, within 30 days. A signed letter from the principal of the Assignee Agency is an acceptable form of notification in lieu of a death certificate.

Selling an Active Commissionable Book of Business

Subject to CMS rules and regulations, as amended from time to time, and when approved by Cigna Producer Commissions management, Agents and Agencies may be permitted to transfer their active commissionable Book of Business (BOB) to another Agent or Agency in good standing with Cigna. The transfer must be the result of an acquisition, merger, sale, consolidation or other legal transaction, and the transferring Agent/Agency must be terminating their contract with Cigna as a result of the sale/transfer.

To qualify for review, the transferring Agent/Agency must provide the following in writing to Cigna Producer Commissions at least 90 days prior to the effective date of the transfer:

- Current Owner name and writing number
- New Owner name and writing number
- Notarized documentation that demonstrates the legal transfer of the commissionable BOB
- Proposed effective date of transfer
- An attestation from the New Owner that the New Owner shall continue servicing the transferred BOB
- Proof of New Owner's licensure and appointment in all states that the BOB transfer covers (based on each state's regulations)

In addition to the above requirements, if the writing Agent is changing as a result of the transfer, written demonstration that all customers impacted by the BOB transfer have been notified of the change in representation will also be required. Customer notification documents must be retained and provided to Cigna on request in the event of an audit.

Upon Cigna Receipt of Notification

On receipt of the request, Cigna Producer Commissions management will review the information provided and determine if any additional information is needed based on the type of transfer requested. Cigna will review all requests on a case-by-case basis and reserves the right to deny any request that does not meet current standards for approval.

Cigna's contracting policies state that renewal compensation must be paid to the hierarchy in place at the time of sale. Currently, we are unable to move an Agent's book of business when there has been a hierarchy change since the original time of sale. Since book of business transfers must be done for the entire book of business when the above applies, we are unable to approve book of business transfers due to an impact to the Upline hierarchy's compensation.

Cigna also reserves the right to request any additional documentation not listed above and may designate additional requirements be met as a result of the review process.

If the request is approved, the effective date of the transfer can be no earlier than the first of the month following the date of initial notification indicated above. **Please note that renewal compensation will not be impacted until the next renewal year (i.e., the New Owner/hierarchy will not receive compensation payments from Cigna for the applicable BOB transfer until the annual renewal pay cycle in January).** Completion time varies depending on the BOB size. Cigna shall not be responsible for any payments made to the wrong Agent/Agency if Cigna does not receive at least 90 days' prior advance notice of the proposed transfer's effective date. All future debt for customer terminations will be the responsibility of the Agent/Agency that was originally paid compensation for the relevant plan year.

In order for the new Agent or Agency to receive ongoing renewal compensation, all regular commissionable criteria must be met, including, but not limited to, an active Cigna contract, appropriate state licensure and appointment, and successful completion of plan-year certification and/or attestation.

Deceased Agent Active Commissionable Book of Business Transfer

Cigna may permit the transfer of a deceased Agent's active commissionable BOB to their surviving spouse or business partner, providing he or she is actively contracted with Cigna, holds active state licenses and appointments in all relevant states, and has completed certification for the current plan year.

To qualify for review, the following must be provided to Cigna Producer Commissions in writing within 60 days of the deceased Agent's passing:

- Deceased Agent's name and writing number
- New Agent's name and writing number (surviving spouse/business partner)
- An attestation from the New Agent that he or she will continue servicing the transferred BOB
- Proof of New Agent's licensure and appointment in all states that the BOB transfer covers (based on each state's regulations)

While we know this may be a difficult time, please note that Cigna's contracting policies state that renewal compensation must be paid to the hierarchy in place at the time of sale. Currently, we are unable to move an Agent's book of business when there has been a hierarchy change since the original time of sale. Since book of business transfers must be done for the entire book of business when the above applies, we are unable to approve book of business transfers due to an impact to the Upline hierarchy's compensation.

In addition to the above requirements, Cigna may also require the following in accordance with the standard BOB transfer requirements (outlined in the previous section):

- Written demonstration that all customers impacted by the BOB transfer have been notified of the change in representation.

On receipt of the request, Cigna Producer Commissions management will review the information provided and determine if the request will be approved. All requests will be reviewed on a case-by-case basis, and Cigna reserves the right to deny any request that does not meet current standards for approval. Cigna also reserves the right to request any additional documentation not listed above and may designate additional requirements be met as a result of the review process. If the request is approved, the effective date of the transfer can be no earlier than the first of the month following the date of initial notification.

In order for the new Agent to receive ongoing renewal compensation, all regular commissionable criteria must be met, including, but not limited to, an active Cigna contract, appropriate state licensure and appointment, and successful completion of plan-year certification.

SECTION X

DOWNGRADE, SUSPENSION AND TERMINATION

Agency Downgrade

Agencies should work with their Upline if there are questions or concerns related to meeting or maintaining the minimum Agent requirement. Cigna Medicare reserves the right to review all Agency-level contracts to ensure the specific requirements are being met. In the event an Agency is downgraded or terminated due to failure to meet engagement criteria, Cigna Medicare will notify the Agency's topline.

- **An Agency downgrade to a non-Agency level or to a Personal Business Entity level will result in forfeiture of administrative fees.**
- An Agency downgrade to another Agency level (GA or above) will result in administrative fees being paid according to the Agency level in place as of the date of enrollment.
  - **Example:** Enrollments completed at SGA level will continue to be paid at the SGA level, while enrollments completed after the downgrade will be paid at the new administrative fee level (MGA/ GA).
- When an Agency downgrades, Downline Agent/ Agencies may be moved to the next direct Upline, as needed, based on the downgraded Agency's new level. Downline Agent and Agency commissions will continue to be paid provided Agents and Agencies meet all required validations (contracted, certified/ attestation completed, licensed and appointed) and the customer remains enrolled.

Suspension of Sales and Marketing

Cigna Medicare expects all Agencies/Agents/Employees to comply with all CMS regulations, state and federal laws, guidelines, and Cigna Medicare rules, policies, and procedures.

- If at any time individual performance or action damages or threatens to damage any Medicare beneficiaries or the reputation of Cigna Medicare or does not meet Cigna Medicare's standards, Cigna Medicare can, at its discretion, suspend sales and marketing activities.
- A determination to suspend can also be based on the severity of an allegation(s), the number of pending complaints or investigations, the nature and credibility of information initially provided, and/or the number of customers or beneficiaries affected and can be based on other oversight criteria. In such cases, suspension is in effect until the investigation is completed, a final disciplinary recommendation has been made and any required remediation has been completed.
- Cigna Medicare may be required to report the suspension to the applicable state or government Agency.

Suspension Process

- When a determination to suspend sales and marketing activities is made, a suspension notification from Cigna Medicare Contracting will be sent, with a copy sent to applicable Topline.
- Agents cannot solicit or write new business while under suspension. If new business is written during the suspension period, Agents will not be eligible for commissions and/or renewals. Further disciplinary action may be levied.
- Cigna Medicare will satisfy suspension reporting requirements with notification to the appropriate state Agencies.
- Cigna is not obligated to report the status to a government agency unless further action is required.

Temporary Hold Status

Depending on the circumstances, an Agent may be placed on "temporary hold." When a recommendation to place an Agent's sales and marketing status on temporary hold is made, the Agent will be sent a temporary hold notification from Cigna Medicare Contracting, with a copy sent to the applicable Topline. The status of "temporary hold" means:

- **Agent may not** solicit or sell Cigna Medicare products while on a temporary hold status.
- Any outstanding commissions will continue to be paid during this period.
- Cigna is not obligated to report the status to a government agency unless further action is required.

Agent Termination: Not-For-Cause and For-Cause

All contract and appointment terminations are classified not-for-cause or for-cause. Termination of appointment may be recommended by Cigna Medicare, the Topline or immediate Upline, a regulatory Agency, or a state Department of Insurance; additionally, an Agent may request a voluntary termination or an alteration to the Topline hierarchy.

Not-For-Cause Termination (Agent/Agency)

A not-for-cause termination can be initiated by a Topline or immediate Upline, Cigna Medicare, or an Agent for any reason including, but not limited to, relocation, and expired license, and expired Errors and Omissions insurance coverage. Please review the following not-for-cause termination process:

- Termination requests must be submitted in writing via email or a termination form outlining the reason for termination. The termination form must be obtained from and returned to **CARL** via email.
- The terminated Agent/Agency will be sent a termination notification, which will identify the effective termination date.
- State-level appointments will be terminated in conjunction with the date the agreement is terminated.
- When an Agency is terminated, any Downline Agents/Agencies will be moved under the next highest entity in the hierarchy.
- Termination will cease payment of commissions.

Not-For-Cause Termination – Agent

If an Agent is terminated by a Topline Agency or falls under a Topline Agency that will no longer hold a contract with Cigna Medicare but is in good standing with Cigna Medicare (i.e., not under investigation internally or externally, have acceptable compliance metrics, sufficient sales, not in debt to Cigna Medicare and/or current Upline, do not have third-party paper prohibiting a move in hierarchy), the Agent may re-contract under a new hierarchy or direct to Cigna Medicare. If recontracting, onboarding, certification and activation are complete within thirty (30) calendar days of the termination date, commissions and renewals may be restored.

Not-For-Cause Termination – Agency

If an Agency is terminated by its Topline or falls under a Topline Agency that will no longer hold a contract with Cigna Medicare and is in good standing with Cigna Medicare, the Agency may re-contract under a new hierarchy or direct to Cigna Medicare.

For-Cause Termination

A for-cause termination can be initiated by Cigna Medicare or by an external regulatory Agency.

- A for-cause termination notification letter, detailing the offense, termination effective date and the appeal process, is sent to the terminated party via certified U.S. mail.
- The applicable Topline or Upline is emailed a copy of the notification letter.
- State-level appointments will be terminated in conjunction with federal and state requirements.

Communication to any state in which the Agent/Agency is appointed will be made in accordance with all federal and state requirements.

- When an Agency is terminated, any active Downline Agents/Agencies will be moved under the next highest entity in the hierarchy.
- Termination will result in the Agent/Agency being ineligible to receive any further commission payments.
- In some cases, as directed by the Cigna Medicare SDAP, the Agent/Agency's profile in the contracting systems could also be marked as "Do Not Recontract."
- If terminated "for-cause" or "not for-cause" due to compliance and/or other disciplinary reason, per Cigna policy, Agent/Agency must wait at least one year before applying for reinstatement.

"Do Not Recontract" Reinstatement Process

If an Agent or Agency is flagged "Do Not Re-contract," they may not contract with any Cigna company or its affiliates, including, but not limited to, all Cigna Medicare and commercial products. To request an appeal to the "Do Not Re-contract" status, use the following process:

- Upon receipt of the Cigna termination letter, an appeal must be submitted via email to request reinstatement of appointment within (10) business days to: **CARL**.

- If there are no open violations against the Agent/Agency, the request will be considered at the SDAP meeting. If there are open violations, the Agent/Agency and the appropriate sales leader will be notified via email or telephone that the reinstatement request will not go to the committee until the open violations have been closed.
- The reinstatement request, along with any pertinent new information, is reviewed by the SDAP. When the committee has made a determination, the outcome will be documented in the Agent file and notification in writing will be sent via email with an electronic copy to the applicable Topline.
- If Agent/Agency is approved for reinstatement, re-contracting is required and a new contracting packet must be submitted.
- If Agent/Agency is not approved for reinstatement, Agent/Agency must wait at least one year before submitting any additional requests for reconsideration.

SECTION XI

RESOURCES

Helpful Links

Cigna Producers' University (Pinpoint)

https://cignamedicareproducers.com/Apps/Medicare/Default.aspx

Many Cigna resources, including training, forms, reporting and policies, are located within Producers' University.

Cigna for Brokers

https://cignaforbrokers.com/web/login

This is our portal that allows Agents to view and manage leads, appointments and applications.

Producer Express (Producer Onboarding)

https://px.sircon.com

Database of active producers used to house Agents' demographic information.

Cigna

Cigna.com

Cigna's corporate public website.

Provider Lookup Tool

https://providersearch.hsconnectonline.com/Directory/

With this online tool, Agents can locate network providers.

CustomPoint

https://custompoint.rrd.com

Cigna's web-based tool allowing External Agents to customize and order Sales Kits and marketing collateral to better educate customers on plan information.

E-enrollment

https://broker.hsconnectonline.com/Account/Login?ReturnUrl=%2f

This enrollment tool allows External Agents to walk an enrollee through a quick, paperless electronic application.

Cigna Quick Reference Guide

https://cignamedicareproducers.com/Apps/Medicare/Assets/Resources/Cigna%20Quick%20Reference%20Guide.pdf

These Cigna-created tools best support Agent success.

Cigna Site Credentials

https://cignamedicareproducers.com/Apps/Medicare/Assets/Resources/Cigna%20Site%20Credentials.pdf

First-time login instructions for various Agent sites Cigna offers can be found here.

Key Contacts

Cigna Agent Resource Line (CARL)

Phone: **1-866-442-7516** Email: **CARL@Cigna.com**

Hours of operation:

- October 1 – December 7 **(AEP)**:
  - Monday – Saturday, 7 a.m. – 9 p.m. CST, and Sunday, 9:30 a.m. – 6 p.m. CST
- December 8 – December 31, April 1 – September 30 **(Lock-In)**:
  - Monday – Friday, 7 a.m. – 6 p.m. CST
- January 1 – March 31 **(OEP)**:
  - Monday – Saturday, 7 a.m. – 6 p.m. CST